Pfizer GEODON™ (ziprasidone HCl) SAMPLE

Patient Assistance Program
Enrollment Form—Prescriber Information

PO Box 52119 • Phoenix, AZ • 85072
1-866-4GEODON (1-866-443-6366) • 1-866-229-2255 Fax

PRESCRIBER INFORMATION

Prescriber Name: X. DOE, M.D.
(First) (MI) (Last)

DEA Number: 987654321 or State Licensing Number: ABC1234

Facility Name: COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Shipping Address: 550 SO. VERMONT, ROOM 903

City: LOS ANGELES State: CA ZIP: 90020

Telephone: 213-123-4567 Fax: 213-456-7890

Office Contact Name: MARY SMITH Title: FINANCIAL SERVICES

PRESCRIPTION INFORMATION

This section of the form will serve as a GEODON prescription.

PATIENT NAME: JOHN DOE

REQUESTED MEDICATION:

- ☑ GEODON **20-mg** Capsules bid with food
- ☐ GEODON **40-mg** Capsules bid with food
- ☐ GEODON **60-mg** Capsules bid with food
- ☐ GEODON **80-mg** Capsules bid with food

Quantity = 180 capsules (3 bottles) shipped as a 90-day supply.

If funding is not found for the patient during the reimbursement search based on information provided on this form, the patient's eligibility for participation in the GEODON Patient Assistance program (the program) will be determined. If the patient is approved, a three-month supply will be shipped to the prescriber's office at the address stated above (no PO Boxes). For patients who appear to be qualified for public funding or other insurance, only a 1-month supply will be shipped to their prescribers. The prescriber will be responsible for dispensing the medication to the patient named on this application.

The program reserves the right to refer patients/prescribers to other sources of reimbursement before consideration for the program and, if applicable, to request that the prescriber/patient provide evidence of denial of this application for financial resources.

I understand that the program may be changed or terminated without prior notice. My signature certifies that GEODON is appropriate for the above patient's therapy and that medication received in response to this application will be used to treat only the above-named patient. The medication will not be offered for sale, trade, or barter. My signature also attests to the validity of the financial information provided by the patient.

Prescriber Signature: SSSSSSSSSSSSSS Date: 1/2/3456

Please fax this form to 1-866-229-2255 or mail to the above address.
If you have questions, please call 1-866-4GEODON (1-866-443-6366).

SAMPLE

Pfizer GEODON™ (ziprasidone HCl) SAMPLE

Patient Assistance Program
Enrollment Form—Patient Information

PO Box 52119 • Phoenix, AZ • 85072
1-866-4GEODON (1-866-443-6366) • 1-866-229-2255 Fax

PATIENT INFORMATION

Name (First)	(MI)	(Last)	Date of Birth
JOHN DOE			01/02/1945

Mailing Address	Apt #
123 SOUTH STREET	10

City	State	ZIP
LOS AGELES	CA	9000000

Social Security #	US Resident	Number of People in Household	Are You Legally Disabled?	Are You a Veteran?	Are You the Spouse of a Veteran?
123 - 45- 6789	☑ Yes ☐ No	1	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No

PATIENT FINANCIAL INFORMATION

Total Household Monthly Income: Salary ☐ Alimony ☐ Child Support ☐ Unemployment ☐ Workers' Compensation ☐	
SS—Social Security (Retirement/Survivor) ☐ SSDI—Social Security Disability Income ☐ SSI—Supplemental Security Income ☐	
Pension/Retirement ☐ Military Pension ☐ IRA or 401K Distribution ☐ Interest/Dividends/Royalties ☐	
General Relief/Assistance ☑ Public Assistance (ie, TANF) ☐	$200.00
Other—Please Explain:	
Total	$ 200.00

INSURANCE INFORMATION

	Does the Patient Have? Yes/No	If NO, Has the Patient Applied? Yes/No	If YES, Date of Application	Status Pending/Denied
Medicare	NO	NO		
Medicaid	NO	YES	3/1/2004	PENDING
Veterans Administration	NO	NO		
Indian Health Services	NO	NO		
Other Public Health Assistance (Specify)	NO	NONE		

PRIVATE INSURANCE INFORMATION

Primary Insurance (Specify)	NONE	Telephone # ( )	Policy ID #	Group #	Group Name
Secondary Insurance (Specify)	NONE	Telephone # ( )	Policy ID #	Group #	Group Name

I certify that the information provided is complete and accurate to the best of my knowledge. By signing this application, I understand that any assistance in the form of free medication is contingent upon my ability to meet the eligibility criteria for the program and that application to the program does not guarantee inclusion. I also understand that Pfizer Inc. reserves the right at any time to modify or discontinue this program without notice. I authorize the GEODON Patient Assistance Program to obtain information from my insurance company, prescriber, or employer to verify the accuracy and completeness of this application. I understand that my assistance is temporary, and I may be asked to reapply at designated intervals.

Patient or Guardian Signature: SSSSSSSSSSSSSS Date: 1/2/3456

Name of Person Submitting Application: SSSSSSSSSS Phone Number: (213) 333-4444
(Please Print)

Please fax this form to 1-866-229-2255 or mail to the above address.
If you have questions, please call 1-866-4GEODON (1-866-443-6366).

SAMPLE